

**STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
DIVISION OF WORKERS' COMPENSATION**

**INITIAL STATEMENT OF REASONS**

**Subject Matter of Proposed Regulations:  
Workers' Compensation – Official Medical Fee Schedule  
Services Rendered After January 1, 2004**

**TITLE 8, CALIFORNIA CODE OF REGULATIONS  
SECTIONS 9789.10 – 9789.110**

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## **BACKGROUND TO REGULATORY PROCEEDING:**

The Legislature has amended Labor Code Section 5307.1 in Senate Bill 228 (Chapter 639, Statutes of 2003, effective January 1, 2004) to change the manner by which health care providers are compensated for medical services rendered in cases within the jurisdiction of the California workers' compensation system. Under the amended statute, the maximum reasonable fees for medical services commencing January 1, 2004, other than physician services, are 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system or 100 percent of the fees prescribed in the relevant Medi-Cal payment system. The statute also provides that for the Calendar Years 2004 and 2005, the maximum reimbursable fees set forth in the existing Official Medical Fee Schedule for physician services must be reduced by 5 percent.

To meet the January 1, 2004 implementation date mandated by amended Labor Code § 5307.1, the Division of Workers' Compensation (hereafter "DWC" or "Division") adopted emergency regulations, which are now set forth at Title 8, California Code of Regulations § 9789.10 to 9789.110. The emergency regulations, applicable to all medical treatment rendered in workers' compensation cases after January 1, 2004, were approved by the Office of Administrative Law and filed with the Secretary of State. The Division now seeks to complete its rulemaking action and permanently adopt the emergency regulations.

Proposed Sections 9789.10 and 9789.11 implement subdivision (k) of amended Labor Code § 5307.1, which requires that for the Calendar Years 2004 and 2005 the maximum reimbursable fees set forth in the existing Official Medical Fee Schedule for physician services must be reduced by five (5) percent. Proposed Sections 9789.20 through 9789.24 set forth the general information, definitions and payment schedule for the Inpatient Hospital Fee Schedule section of the Official Medical Fee schedule. Proposed Sections 9789.30 through 9789.38 set forth the definitions and fee schedule governing the payment of medical services provided by outpatient hospital departments and ambulatory surgical centers.

Proposed Section 9789.50, 9789.60, and 9789.90 set forth the payment schedules for, respectively, Pathology and Laboratory, Durable Medical Equipment, Prosthetics, Orthotics, Supplies, and Ambulance Services. Proposed Section 9789.110 implements subdivision (g) of Section 5307.1, which requires that the Official Medical Fee Schedule be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems.

Amended Labor Code § 5307.1 mandates that maximum reasonable fees for pharmacy services rendered on or after January 1, 2004 are 100 percent of the fees prescribed in the relevant Medi-Cal payment system. The Administrative Director finds this provision in the statute to be self-executing. To assist providers and payers in determining the correct fees for pharmaceuticals, the Division will post Medi-Cal rates on its Internet website.

## **Section 9789.10      Physician Services – Definition**

### Specific Purpose of Adopted Section 9789.10:

Amended Labor Code § 5307.1(k) provides that the maximum reimbursable fees set forth in the existing Official Medical Fee Schedule for physician services must be reduced by five (5) percent for the Calendar Years 2004 and 2005. The Administrative Director has discretion to reduce individual procedure codes by different amounts, but in no event shall the Administrative Director reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure. The purpose of this proposed regulation is to define key terms in order to apply the mandated five percent reduction and to ensure that their content and meaning is clearly understood by the regulated community.

### Necessity:

To determine the maximum reimbursable fee for an identified physician service, it is necessary to define the separate components that are used to calculate the fee. “Physician services” is defined to identify the medical treatment procedures whose maximum reimbursable fees are subject to the 5% reduction. “CPT<sup>®</sup>” is defined to identify the licensed procedure coding system utilized in the Official Medical Fee Schedule. “RVU” is defined to identify the relative value unit for a particular procedure set forth in the Official Medical Fee Schedule 2003. “Conversion factor,” or “CF,” is defined to clarify the factor that is multiplied by the listed relative value unit of each individual procedure code in the Official Medical Fee Schedule to determine the maximum reimbursable physician fee. For anesthesia services, “basic value” is defined to identify the value unit for an anesthesia procedure. “Modifying units” is defined to identify the anesthesia modifiers and qualifying circumstances. “Time value” is defined to identify the unit of time indicating the duration of an anesthesia procedure.

To apply the mandatory five percent reduction, it is necessary to define and establish the source of existing fees (as of December 31, 2003), the current Medicare rates for physician services, the factor used to implement the reduction, and the new rates. “Official Medical Fee Schedule 2003” (or “OMFS 2003”) is defined to identify the maximum reimbursable fees for all medical services, goods, and treatment rendered *before* January 1, 2004. “Medicare rate” is defined as the Calendar Year 2004 physician fee schedule established by the Center for Medicare & Medicaid Services of the United States Department of Health and Human Services (“CMS”). The Medicare rate for each procedure is derived by utilizing the non-facility rate (or facility rate if no non-facility rate exists), and a weighted average geographic adjustment factor (“GAF”) of 1.063. The GAF was based on an estimation by the Lewin Group that the average conversion factor for the California workers’ compensation program is six percent higher than the national conversion factor. “Percent reduction calculation” is defined to clarify the factor that is to be used for the purpose of applying the percentage reduction in fees for physician services rendered after January 1, 2004. “Official Medical Fee Schedule” is defined to identify the maximum reimbursable fees for all medical services, goods, and treatment rendered after January 1, 2004.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Physicians' Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association.
2. 68 Federal Register No. 216, pages 63262 through 63386 (November 7, 2003).
3. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for the Commission of Health and Safety and Workers' Compensation, Santa Monica, CA: Rand – Institute for Civil Justice, June, 2003. (See n. 20 for use of 1.06 GAF.)
4. The Lewin Group, California Workers' Compensation RBRVS Study, draft report prepared for the Industrial Medical Council, Falls Church, VA: The Lewin Group, October 8, 2002.
5. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
6. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
7. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).

Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactment that mandates a five percent reduction in fees paid for physician services under the OMFS in effect on December 31, 2003. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems to reflect the five percent reduction. Physician offices may have to purchase updated OMFS groundrules for medical fee schedules; current version of schedule costs \$38. Businesses can download copies of pricing or ways to determine pricing for specific services from the DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

## **Section 9789.11 Physician Services Rendered After January 1, 2004**

### Specific Purpose of Adopted Section 9789.11:

Amended Labor Code § 5307.1(k) provides that the maximum reimbursable fees set forth in the existing Official Medical Fee Schedule for physician services must be reduced by five (5) percent for the Calendar Years 2004 and 2005. The Administrative Director has discretion to reduce individual procedure codes by different amounts, but in no event shall the Administrative Director reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure. The purpose of this proposed regulation is to apply the statutory mandate of a five percent fee reduction for physician services.

### Necessity:

To apply the mandated five percent reduction for physician services, it was necessary to first establish the 2004 Medicare rates for physician services in California. The Medicare rate for each procedure is derived by utilizing the procedure's non-facility Medicare rate (or facility rate if no non-facility rate exists) and a California weighted average geographic adjustment factor of 1.063. To apply the five percent reduction mandated by amended Labor Code § 5307.1(k), the maximum allowable reimbursement amount set forth in the OMFS 2003 for each individual procedure code is reduced by five (5) percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100% and 105% of the Medicare rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. An across-the-board five percent reduction of physician services fees was rejected because such a mechanistic approach in fee reductions could lead to an access problem for injured workers: a reduction of fees below Medicare rates may result in physicians refusing to treat injured workers.

To determine the maximum allowable reimbursement for a physician service rendered after January 1, 2004, subdivision (d) of proposed Section 9789.11 utilizes the following formula:  $\text{RVU} \times \text{conversion factor} \times \text{percentage reduction calculation}$  (the percentage difference between the OMFS 2003 fee and the 2004 Medicare rates) = maximum reasonable fee before application of ground rules. Applicable ground rules as set forth in the OMFS 2003 and in the "General Information and Instructions, Effective for Dates of Service after January 1, 2004," are then applied to calculate the maximum reasonable fee. For anesthesia services, the following formula

is utilized: (basic value + modifying units (if any) + time value) × (conversion factor × .95) = maximum reasonable fee. Since anesthesia rates in the OMFS are substantially above the 2004 Medicare rates, an across the board five percent reduction (reflected in the conversion factor) is appropriate. To assist the regulated community in determining the maximum reimbursable fees for physician services rendered after January 1, 2004, a table (“OMFS Physician Services Fees for Services Rendered after January 1, 2004”), which sets forth each individual procedure code with its corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%), and maximum reimbursable fee, is incorporated by reference as subdivision (c).

**NOTE: On January 7, 2004, subsequent to the approval of the OMFS Emergency Regulations, the Centers for Medicare and Medicaid Services published an interim final rule implementing the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173. The interim final rule, found at 69 Federal Register No. 4, pages 1084 through 1267, sets forth changes to relative value units for physician fee schedule services for Calendar Year 2004. The Division recognizes that CMS’ changes to the relative value units may affect the Division’s computation of the percent reduction calculation set forth in “Table A- OMFS Physician Services Fees for Services Rendered after January 1, 2004.” The Division will review its estimation of the 2004 Medicare rates, taking into consideration the new relative value units, and correct the percent reduction calculations as necessary. A corrected Table A will be provided to the public in a 15 day comment period.**

Subdivision (e) of proposed Section 9789.11 lists procedures in the Pathology and Laboratory section of the OMFS 2003 that are deemed to be physician services and therefore subject to the five percent reduction required by this proposed regulation. The subdivision also lists those procedures that have been determined not to be physician services. Such procedures are subject to the Clinical Laboratory Fee Schedule set forth in proposed Section 9789.50.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers’ Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Physicians’ Current Procedural Terminology (CPT) 1997, copyright 1996, American Medical Association.
2. 68 Federal Register No. 216, pages 63262 through 63386 (November 7, 2003).
3. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers’ Compensation Program, report prepared for the Commission of Health and Safety and Workers’ Compensation, Santa Monica, CA: Rand – Institute for Civil Justice, June, 2003.
4. The Lewin Group, California Workers’ Compensation RBRVS Study, draft report prepared for the Industrial Medical Council, Falls Church, VA: The Lewin Group, October 8, 2002.

5. Table A, "OMFS Physician Services Fees for Services Rendered after January 1, 2004," prepared for the Division of Workers' Compensation by the California Medical Association, in conjunction with the California Workers' Compensation Institute.
6. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
7. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
8. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactment that mandates a five percent reduction in fees paid for physician services under the OMFS in effect on December 31, 2003. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems to reflect the five percent reduction. Physician offices may have to purchase updated OMFS groundrules for medical fee schedules; current version of schedule costs \$38. Businesses can download copies of pricing or ways to determine pricing for specific services from the DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

#### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

## **Section 9789.20      General Information for Inpatient Hospital Fee Schedule – Discharge after January 1, 2004**

### Specific Purpose of Adopted Section 9789.20:

In compliance with amended Labor Code §5307.1 (effective January 1, 2004), Section 9789.20 sets forth the general rules pertaining to the Inpatient Hospital Fee Schedule section of the Official Medical Fee Schedule. The purpose of the regulation is to set forth that the Inpatient Hospital Fee Schedule applies to services with a date of discharge after January 1, 2004, and to inform the regulated public that the schedule will be adjusted to conform to relevant changes in the Medicare payment schedule no later than 60 days after the effective date of those changes, and that updates will be posted on the Division's website.

### Necessity:

Labor Code § 5307.1, as amended by SB 228, provides that all fees shall be paid in accordance with the fee-related structure and rules of the relevant Medicare payment systems and that the maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute. Although amended Labor Code § 5307.1 requires the Administrative Director to adopt regulations for fees in accordance with the Medicare payment system, Medicare employs many special rules and exceptions to its basic formulaic payment schedule and is periodically updated. Section 9789.20 is necessary to state which bills are subject to the Inpatient Hospital Fee Schedule and how and when the Inpatient Hospital Fee Schedule will be adjusted to conform with changes made to Medicare.

### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System



- Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
  5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
  6. Title 42, Code of Federal Regulations, Section 412, specifically subparts B, C, F and G.
  7. Fiscal Year 2004 Prospective Payment Impact File (October 2003 Update) (IMPFILE04) published by the federal Centers for Medicare & Medicaid Services (CMS).
  8. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
  9. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
  10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
  11. Medicare's National Adjusted Operating Standardized Amounts, Labor/NonLabor (Table 1A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57735).
  12. Comments received in response to the OMFS Emergency rulemaking filing with OAL.

Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. This regulation clarifies the legislative mandates to adopt Medicare fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

### **Section 9789.21 Definitions for Inpatient Hospital Fee Schedule**

#### Specific Purpose of Adopted Section 9789.21:

Amended Labor Code § 5301.7 provides that the maximum reasonable fees for inpatient hospital services shall be 120 percent of the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute. The purpose of this regulation is to set forth the definitions of terms used in the inpatient fee schedule regulations and the formulas needed in order to determine the maximum payment for medical services so that the Inpatient Fee Schedule will comply with the mandate of Labor Code § 5307.1. The regulation defines the terms by setting forth the appropriate formulas and setting forth where the term is specified in the Federal Register or Code of Regulations. The definition of “Composite factor” in Subdivision (d)(3) has been amended to reflect the changes that have been made to Section 9789.23 since the adoption of the emergency regulations.

#### Necessity:

Although amended Labor Code § 5307.1 requires the Administrative Director to adopt regulations for fees in accordance with the Medicare payment system, Medicare employs many special rules and exceptions to its basic formulaic payment schedule. This regulation is necessary because the statute is not self-executing. To determine the maximum reimbursable fee for inpatient hospital services, it is necessary to define the separate components that are used to calculate the fee. Further, it is necessary to define the key terms used in applying the inpatient fee schedule to ensure that the content and meaning of the regulations is clearly understood by the regulated community.

#### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers’ Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers’ Compensation Program, report prepared for Commissions on Health and Safety and Workers’ Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers’ Compensation, Workers’ Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair,

- California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
6. Title 42, Code of Federal Regulations, Section 412, specifically subparts B, C, F and G.
7. Fiscal Year 2004 Prospective Payment Impact File (October 2003 Update) (IMPFILE04) published by the federal Centers for Medicare & Medicaid Services (CMS).
8. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
9. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
11. Medicare's National Adjusted Operating Standardized Amounts, Labor/NonLabor (Table 1A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57735).
12. Comments received in response to the OMFS Emergency rulemaking filing with OAL.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. This regulation clarifies the legislative mandates to adopt Medicare fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

**Section 9789.22      Payment of Inpatient Hospital Services**

Specific Purpose of Adopted Section 9789.22:

Amended Labor Code 5301.7 provides that all fees by a hospital for inpatient services shall be in accordance with the fee-related structure and rules of the relevant Medicare payment systems and that the maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the Medicare payment system before the application of the inflation factor set forth in the statute. This purpose of this regulation is to provide the basic procedures for the payment of inpatient services: the formula to determine the maximum payment for inpatient medical services, the requirement for health facilities to provide specific information in their bills to allow payers to determine the maximum payment, the formula for cost outlier cases, an exception for implantable hardware, a new technology pass-through, a modified factor for sole community hospitals, an explanation of how payment for transfers will be calculated, exemptions for certain types of hospitals, and the procedure for a request for redetermination.

Necessity:

This regulation is necessary in order to implement Labor Code § 5307.1, as amended by SB 228. Although amended Labor Code § 5307.1 requires the Administrative Director to adopt regulations for fees in accordance with the Medicare payment system, Medicare employs many special rules and exceptions to its basic formulaic payment schedule. This regulation provides the basic formula and sets forth the specific exceptions that apply.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair,

- California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
  4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
  5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
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  8. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
  9. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
  10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
  11. Medicare's National Adjusted Operating Standardized Amounts, Labor/NonLabor (Table 1A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57735).
  12. Comments received in response to the OMFS Emergency rulemaking filing with OAL.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. This regulation clarifies the legislative mandates to adopt Medicare fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

**Section 9789.23      Hospital Cost to Charge Ratios, Hospital Specific Outlier Factors, and Hospital Composite Factors**

Specific Purpose of Adopted Section 9789.23:

The purpose of this section is to set forth a table that provides the Medical Provider Number, the hospital name, the Inpatient Hospital Operating Cost to Charge Ratio, Capital Cost to Charge Ratio, Total Cost to Charge Ratio, Hospital Specific Outlier, and Composite Factors. These factors are used to determine the amount of the outliers, to determine if the provider is entitled to an outlier, and to determine the maximum payment for inpatient medical services. The cost to charge ratios have been added to the chart since the adoption of the emergency regulations in response to requests from the public. This table replaces the prior Section 9789.23 which instead had columns entitled “provider,” hospital name,” “composite factor,” “adjusted composite factor,” and “hospital specific outlier factor.”

Necessity:

The section allows the user to determine the appropriate Medical Provider Number used by Medicare, the Inpatient Hospital Operating Cost to Charge Ratio, Capital Cost to Charge Ratio, Total Cost to Charge Ratio, Hospital Specific Outlier, and Composite Factors by referring to the table. The factors are necessary in order to calculate to determine the amount of the outliers, to determine if the provider is entitled to an outlier, and to determine the maximum payment for inpatient medical services.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers’ Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers’ Compensation Program, report prepared for Commissions on Health and Safety and Workers’ Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers’ Compensation, Workers’ Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair,

- California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
  4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
  5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
  6. Title 42, Code of Federal Regulations, Section 412, specifically subparts B, C, F and G.
  7. Fiscal Year 2004 Prospective Payment Impact File (October 2003 Update) (IMPFILE04) published by the federal Centers for Medicare & Medicaid Services (CMS).
  8. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
  9. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
  10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
  11. Medicare's National Adjusted Operating Standardized Amounts, Labor/NonLabor (Table 1A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57735).
  12. Comments received in response to the OMFS Emergency rulemaking filing with OAL.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. This regulation clarifies the legislative mandates to adopt the Medicare fee schedule. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

**Section 9789.24 Diagnostic Related Groups, Relative Weights, Geometric Mean Length of Stay**

Specific Purpose of Adopted Section 9789.24:

The purpose of this section is to provide a table that lists the DRGs (diagnosis related groups), relative weights and geometric length of stay. The DRG weights and geometric lengths of stay are assigned by the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services. The provider requires this information in order to bill for services and the payer requires this information in order to calculate the maximum fee for services.

Necessity:

This section is necessary because in order for a provider to bill for services and the payer to calculate the maximum fee for services, the regulated public needs to know the DRGs (diagnosis related groups), relative weights and geometric length of stay.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).



4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
6. Title 42, Code of Federal Regulations, Section 412, specifically subparts B, C, F and G.
7. Fiscal Year 2004 Prospective Payment Impact File (October 2003 Update) (IMPFIL04) published by the federal Centers for Medicare & Medicaid Services (CMS).
8. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
9. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
11. Medicare's National Adjusted Operating Standardized Amounts, Labor/NonLabor (Table 1A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57735).
12. Comments received in response to the OMFS Emergency rulemaking filing with OAL.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. This regulation clarifies the legislative mandates to adopt Medicare fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

#### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

## **Section 9789.30      Hospital Outpatient Departments and Ambulatory Surgical Centers - Definitions**

### Specific Purpose of Adopted Section 9789.30:

Labor Code § 5301.7 provides that all facility fees for services provided by outpatient hospital departments and ambulatory surgical centers shall be paid in accordance with Medicare's Hospital Outpatient Prospective Payment System, and that the maximum reasonable fees for outpatient facilities fees shall be 120 percent of the fees paid by Medicare for the same services performed in a hospital outpatient department. Prior to January 1, 2004, there was no hospital outpatient department and ambulatory surgical center fee schedule in place for facility's fees for workers' compensation in California. Labor Code § 5301.7 provides that as of January 1, 2004, and until the Administrative Director adopts a schedule, fees shall be no more than 120% of "estimated aggregate" fees paid in the Medicare system. The purpose of this section is to define key terms used in the hospital outpatient department and ambulatory surgical center fee schedule to ensure that their meaning is clearly understood by the regulated community.

### Necessity:

Although amended Labor Code § 5307.1, as amended by SB 228, requires the Administrative Director to adopt regulations for fees in accordance with the Medicare payment system, Medicare employs many special rules and exceptions to its basic formulaic payment schedule. This regulation is necessary because the statute is not self-executing. To determine the maximum allowable payment for services rendered after January 1, 2004 by hospital outpatient departments and ambulatory surgical centers, it is necessary to define the key terms used in applying the outpatient fee schedule to ensure that the content and meaning of the regulation is clearly understood by the regulated community.

### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.

3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
6. American Medical Associations' Physician "Current Procedural Terminology," 2004 Edition.
7. CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS).
8. CMS' FY 2004 Market Inflation Basket of 3.4%, Federal Register, August 1, 2003, Volume 68, at page 45346.
9. CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690.
10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
11. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
12. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
13. Comments received in response to the Official Medical Fee Schedule Emergency rulemaking filing with the Office of Administrative Law.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. Regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

## **Section 9789.31      Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule—Adoption of Standards.**

### Specific Purpose of Adopted Section 9789.31:

In this section the Administrative Director adopts and incorporates by reference the standards relied upon in determining the maximum allowable payment for services rendered after January 1, 2004 by hospital outpatient departments and ambulatory surgical centers. The purpose of this section is to clearly identify the standards being used in the hospital outpatient department and ambulatory surgical center fee schedule.

### Necessity:

Amended Labor Code § 5301.7 provides that the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department. To accomplish the mandate of the legislation, it is necessary to incorporate by reference the CMS 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216. The HOPPS includes Addenda A through J, pages 63478 through 63690. The information contained in CMS's tables set forth in Addenda A through J is used in the various formulae used to determine the maximum facility fee for services performed by an ambulatory surgical center, or by a hospital outpatient department. Addendum A is a table setting forth a list of ambulatory payment classifications (APCs) with status indicators, relative weights, payment rates, and copayment amounts for calendar year 2004. Addendum B is a table setting forth payment status by HCPCS Code and related information for calendar year 2004. Addendum D1 is a table setting forth the payment status indicators for the Hospital Outpatient Prospective Payment System. Addendum D2 is a table setting forth code conditions. Addendum E is a table setting forth CPT codes which would be paid only as inpatient procedures. Addendum H is a table setting forth Medicare's wage index for urban areas. Addendum I is a table setting forth Medicare's wage index for rural areas. Addendum J is a table setting forth CMS' wage index for hospitals that are reclassified. Further, in this subdivision the Administrative Director incorporates by reference the American Medical Associations' Physician Current Procedural Terminology, 2004 Edition, and CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS). The incorporation of these documents is necessary because their components are used in the various formulae used in

the outpatient fee schedule to determine the maximum fee for services provided by outpatient hospital departments and ambulatory surgical centers.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
6. American Medical Associations' Physician "Current Procedural Terminology," 2004 Edition.
7. CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS).
8. CMS' FY 2004 Market Inflation Basket of 3.4%, Federal Register, August 1, 2003, Volume 68, at page 45346.
9. CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690.
10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
11. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).

12. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
13. Comments received in response to the Official Medical Fee Schedule Emergency rulemaking filing with the Office of Administrative Law.

Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. Regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

**Section 9789.32      Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule—Applicability.**

Specific Purpose of Adopted Section 9789.32:

Amended Labor Code § 5301.7 provides that the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department. The purpose of the regulation is to set forth that the Outpatient Department and Ambulatory Surgical Center Fee Schedule applies to services with a date of service after January 1, 2004, it applies to facilities as defined in subdivision (b) of the proposed section, and to identify the facility services that are covered under the fee schedule. The first sentence of subdivision (a) of proposed section 9789.32 has been corrected to reflect the proper proposed sections referenced as Sections 9789.30 through 9789.38. Further, the first sentence of subdivision (b) of proposed Section 9789.32 has been corrected to reflect the proper proposed sections referenced as Sections 9789.30 through 9789.38.

### Necessity:

Amended Labor Code § 5301.7 provides that the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, may not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department. Although amended Labor Code § 5307.1 requires the Administrative Director to adopt regulations for fees in accordance with the Medicare payment system, Medicare employs many rules and exceptions to its basic formulaic payment schedule and is periodically updated. Section 9789.32 is necessary to state which facility services are subject to the Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule.

### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
6. American Medical Associations' Physician "Current Procedural Terminology," 2004 Edition.
7. CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS).
8. CMS' FY 2004 Market Inflation Basket of 3.4%, Federal Register, August 1, 2003, Volume 68, at page 45346.

9. CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690.
10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
11. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
12. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
13. Comments received in response to the Official Medical Fee Schedule Emergency rulemaking filing with the Office of Administrative Law.

Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. Regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

**Section 9789.33      Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule—Determination of Maximum Reasonable Fee.**

Specific Purpose of Adopted Section 9789.33:

Labor Code § 5301.7 provides that all facility fees for services provided by outpatient hospital departments and ambulatory surgical centers shall be paid in accordance with Medicare's Hospital Outpatient Prospective Payment System, and that the maximum reasonable fees for outpatient facilities fees shall be 120 percent of the fees paid by Medicare for the same services



performed in a hospital outpatient department. The purpose of this section is to provide the various formulas to determine the maximum allowable payment for facility fee services provided after January 1, 2004 by outpatient hospital departments and ambulatory surgical centers. The section specifies that the basic formula for maximum allowable payment for facility fee services uses a 1.22 factor in lieu of an additional payment for high cost outlier cases, and provides for an alternative payment methodology for high cost outlier cases. The section also specifies the requirements which must be met in order to qualify for the alternative payment methodology.

Necessity:

This regulation is necessary in order to implement Labor Code § 5307.1, as amended by SB 228. Labor Code § 5301.7 provides that all facility fees for services provided by outpatient hospital departments and ambulatory surgical centers shall be paid in accordance with Medicare's Hospital Outpatient Prospective Payment System, and that the maximum reasonable fees for outpatient facilities fees shall be 120 percent of the fees paid by Medicare for the same services performed in a hospital outpatient department. Prior to January 1, 2004, there was no hospital outpatient department and ambulatory surgical center fee schedule in place for facility fees in workers' compensation in California. Labor Code § 5301.7 states that as of January 1, 2004, and until the administrative director adopts a schedule, fees shall be no more than 120% of "estimated aggregate" fees paid in the Medicare system. The section sets forth two methods for payment of outpatient facility fee services. Under the first method, the payment formula for every procedure will be based on Medicare times 1.22. Under this method the facility does not receive extra payment for high cost outlier cases. The usual 1.20 multiplier is increased to 1.22, as Medicare has reduced the value of all procedures by .2 to reflect the additional amounts paid as outlier payments. Under the second method, both hospitals and ASCs could make an annual election to utilize the second payment methodology. This methodology utilizes the formula of Medicare rate times 1.20, with extra payment for high cost outlier cases. At the time of the election, the hospitals would report their cost to charge ratio utilized by the Medicare fiscal intermediary, and the ASCs would submit a report to allow calculation of a cost to charge ratio. This information must be submitted in the DWC Form 15, Election for High Cost Outlier, as set forth in proposed section 9789.37. In order to further implement the HOPPS, it is necessary to incorporate by reference The OPSS rules in 42 C.F.R. § 419.44 regarding reimbursement for multiple procedures, the OPSS rules in 42 C.F.R. §§ 419.62, 419.64, and 419.66 regarding transitional pass-through payments for innovative medical devices, drugs and biologicals, and to clarify that the payment determined under subdivisions subdivisions (a) and (b) of the proposed section include reimbursement for all of the included cost items specified in 42 CFR § 419.2(b).

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and

- Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
  3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
  4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
  5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
  6. American Medical Associations' Physician "Current Procedural Terminology," 2004 Edition.
  7. CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS).
  8. CMS' FY 2004 Market Inflation Basket of 3.4%, Federal Register, August 1, 2003, Volume 68, at page 45346.
  9. CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690.
  10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
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  12. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
  13. Comments received in response to the Official Medical Fee Schedule Emergency rulemaking filing with the Office of Administrative Law.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. Regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising

and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

**Section 9789.34      Table A.**

Specific Purpose of Adopted Section 9789.34:

The purpose of this section is to set forth a table that provides the “adjusted conversion factor,” which incorporates the standard factor for payment of facility fees provided by the ambulatory surgical centers and non-listed hospitals. The table lists the MSA Code, the urban and rural areas, the counties, the applicable wage index, and the “adjusted conversion factor” before the California Workers’ Compensation adjustment factor for payment of facility fees provided by the ambulatory surgical centers and non-listed hospitals. The “adjusted conversion factor” is based on the following formula:  $\$52.151 \times (.40 + .60 \times \text{applicable wage index}) \times \text{inflation factor of } 1.034$ . The regulated public will be able to use the table to obtain the appropriate “adjusted conversion factor.” The “adjusted conversion factor” is required in order to calculate the maximum allowable facility fee payment for facility fee services provided by the ambulatory surgical centers and non-listed hospitals based on the applicable formula pursuant to proposed Section 9789.33, subdivisions (a) or (b).

Necessity:

The section allows the user to determine appropriate “adjusted conversion factor” by using the table. The “adjusted conversion factor” is required in order to calculate the maximum allowable facility fee payment for facility fee services provided by the ambulatory surgical centers or non-listed hospitals.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers’ Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
6. American Medical Associations' Physician "Current Procedural Terminology," 2004 Edition.
7. CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS).
8. CMS' FY 2004 Market Inflation Basket of 3.4%, Federal Register, August 1, 2003, Volume 68, at page 45346.
9. CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690.
10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
11. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
12. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
13. Comments received in response to the Official Medical Fee Schedule Emergency rulemaking filing with the Office of Administrative Law.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare.

Regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

#### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

#### **Section 9789.35      Table B.**

#### Specific Purpose of Adopted Section 9789.35:

The purpose of this section is to set forth a table that provides the “adjusted conversion factor,” which incorporates the standard factor for payment of facility fees provided by hospital outpatient departments. The table lists the provider number, the name of the hospital, the operating wage index, and the “adjusted conversion factor” before the California Workers’ Compensation adjustment factor for payment of facility fees provided by the hospital outpatient departments. The “adjusted conversion factor” is based on the following formula:  $\$52.151 \times (.40 + .60 \times \text{applicable wage index}) \times \text{inflation factor of } 1.034$ . The regulated public will be able to use the table to obtain the appropriate “adjusted conversion factor.” The “adjusted conversion factor” is required in order to calculate the maximum allowable facility fee payment for facility fee services provided by hospital outpatient departments based on the appropriate formula pursuant to proposed Section 9789.33, subdivisions (a) or (b).

#### Necessity:

The section allows the user to determine appropriate “adjusted conversion factor” by using the table. The “adjusted conversion factor” is required in order to calculate the maximum allowable facility fee payment for facility fee services provided by the hospital outpatient departments.

#### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers’ Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
6. American Medical Associations' Physician "Current Procedural Terminology," 2004 Edition.
7. CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS).
8. CMS' FY 2004 Market Inflation Basket of 3.4%, Federal Register, August 1, 2003, Volume 68, at page 45346.
9. CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690.
10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
11. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
12. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
13. Comments received in response to the Official Medical Fee Schedule Emergency rulemaking filing with the Office of Administrative Law.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. Regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

#### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

### **Section 9789.36      Update of Rules to Reflect Changes in the Medicare Payment System.**

#### Specific Purpose of Adopted Section 9789.36:

Amended Labor Code § 5307.1(g) provides that the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, following consideration of the annual inflation adjustment for facility fees and the annual update in the operating standardized amount and capital standard rate for inpatient hospital services. Subdivision (g)(2) of the statute requires the Administrative Director to determine the effective date of the changes and issue an order, exempt from the rulemaking provisions of the Administrative Procedure Act and the Labor Code informing the public of the changes and their effective date. All orders issued under subdivision (g)(2) must be posted on the Division's Internet website.

The Administrative Director does not find that regulations are necessary to implement amended Labor Code § 5307.1(g). However, proposed Section 9789.36 informs the regulated community where to locate mandatory Medicare updates to the outpatient fee schedule.

#### Necessity:

Proposed Section 9789.36 reflects the statutory mandate that the outpatient fee schedule conform to any relevant changes in the Medicare payment system, and that the Administrative Director issue an order, to be posted on the Division's Internet website, informing the public of such

changes. As the changes will be posted on the Division's Internet Website, the Division determined that the most effective manner to inform the regulated community of this requirement was through regulation.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
6. American Medical Associations' Physician "Current Procedural Terminology," 2004 Edition.
7. CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS).
8. CMS' FY 2004 Market Inflation Basket of 3.4%, Federal Register, August 1, 2003, Volume 68, at page 45346.
9. CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690.
10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
11. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).



12. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
13. Comments received in response to the Official Medical Fee Schedule Emergency rulemaking filing with the Office of Administrative Law.

Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. Regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

**Section 9789.37      DWC Form 15 Election for High Cost Outlier.**

Specific Purpose of Adopted Section 9789.37:

This section sets forth the form which will be used when electing to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) in lieu of the maximum allowable fees set forth pursuant to Section 9789.33(a). The facility electing the high cost outlier payment methodology must file this form with the Administrative Director by March 1 of each year providing the requested information.

Necessity:

Labor Code § 5307.1, as amended by SB 228, mandates that the ambulatory payment classification (APC) system be applied to both the ambulatory surgical centers (ASCs) and the hospital outpatient departments. The hospital outpatient departments have cost to charge ratios that are utilized by the Medicare fiscal intermediary for Medicare payments. The ASC schedule

in Medicare does not utilize cost to charge ratios. By filing this form with the Administrative Director by March 1, both hospitals and ASCs may make an annual election to utilize the alternative payment methodology. This methodology utilizes the formula of Medicare rate times 1.20, with extra payment for high cost outlier cases. At the time of the election, the hospitals are required to report their cost to charge ratio utilized by the Medicare fiscal intermediary, and the ASCs are required to submit a report to allow calculation of a cost to charge ratio.

The hospital outpatient departments must include in the form the cost-to-charge ratio being used by the Medicare fiscal intermediary to determine high cost outlier payments. The ASCs shall include in the form the facility's total operating costs during the preceding calendar year, and the facility's total gross charges for the preceding calendar year. The facility's election form shall further include a completed Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHPD) for the preceding calendar year, which is incorporated by reference. (Note: While ASCs may not typically file Annual Utilization Report of Specialty Clinics with OSHPD, any ASC applying for the alternative payment methodology must file the equivalent, subject to audit by the Division of Workers' Compensation.) A copy of the Annual Utilization Report of Specialty Clinics may be obtained at OSHPD's website or upon request to the Administrative Director. The facility's election form shall further include a certification under penalty of perjury signed by the Chief Executive Officer and a Certified Public Accountant, as to the accuracy of the information and attachment(s). Upon request from the Administrative Director, an independent audit may be conducted at the expense of the ASC. Provision of this information is necessary to process requests electing the high cost outlier payment methodology.

#### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation

- Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
  6. American Medical Associations' Physician "Current Procedural Terminology," 2004 Edition.
  7. CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS).
  8. CMS' FY 2004 Market Inflation Basket of 3.4%, Federal Register, August 1, 2003, Volume 68, at page 45346.
  9. CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690.
  10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
  11. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
  12. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
  13. Comments received in response to the Official Medical Fee Schedule Emergency rulemaking filing with the Office of Administrative Law.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. Regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

### **Section 9789.38      Appendix X.**

#### Specific Purpose of Adopted Section 9789.38:

This Section sets forth the Medicare federal regulations which have been incorporated by reference and/or referred to in the outpatient fee schedule regulations in numerical order.

#### Necessity:

This section setting forth the Medicare federal regulations which have been incorporated by reference and/or referred to in the outpatient fee schedule regulations is necessary in order to allow the user to refer to the regulations without having to conduct extensive research.

#### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).

5. The California Commission on Health and Safety and Workers' Compensation, Inpatient Hospital Fee Schedule and Outpatient Surgery Study Final Report, report prepared by Gerald F. Kominski, PhD, Laura B. Gardner, MD, MPH, PhD, December 2001.
6. American Medical Associations' Physician "Current Procedural Terminology," 2004 Edition.
7. CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS).
8. CMS' FY 2004 Market Inflation Basket of 3.4%, Federal Register, August 1, 2003, Volume 68, at page 45346.
9. CMS' 2004 Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register on November 7, 2003, Volume 68, No. 216, Addenda A through J, pages 63478 through 63690.
10. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Urban Areas (Table 4A, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57736).
11. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Rural Areas (Table 4B, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57743).
12. Medicare's Wage Index and Capital Geographic Adjustment Factor (GAF) for Hospitals that are Reclassified (Table 4C, Federal Register, Vol. 68, No. 193, October 6, 2003, page 57744).
13. Comments received in response to the Official Medical Fee Schedule Emergency rulemaking filing with the Office of Administrative Law.

#### Business Impact:

The business impact is unknown but fairly small. The costs are primarily due not to the regulations but to the legislative enactments that link medical bill reimbursements to Medicare. Regulations are to clarify legislative mandates to adopt Medicare and Medi-Cal fee schedules. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

The regulation does not mandate the use of specific technologies or equipment.

#### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

## **Section 9789.40      Pharmacy**

### Specific Purpose of Adopted Section 9789.40:

Amended Labor Code § 5307.1 mandates that pharmacy services rendered on or after January 1, 2004 must be paid at 100 percent of the fees prescribed in the relevant Medi-Cal payment system. The Administrative Director does not find that regulations are necessary to implement this section. However, to assist providers and payers in determining the correct fees for pharmaceuticals, the Division will post Medi-Cal rates on its Internet website and provide such rates upon written request. This regulation notifies the regulated community of this service.

### Necessity:

Proposed Section 9789.40 reflects the statutory mandate that pharmacy services rendered on or after January 1, 2004 must be paid at 100% of the current Medi-Cal rates. As the Medi-Cal rates will be provided on the Division's Internet Website and provided upon written request, the Division determined that the most effective manner to inform the regulated community of this service was through regulation.

### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
2. Neuhauser, F., Swedlow, A., Gardner, L., and Edelstein, E., Study of the Cost of Pharmaceuticals in Workers' Compensation, a report prepared for the Commission on Health and Safety and Workers' Compensation, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, June 2000.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).

### Business Impact:

This regulation will not have a significant effect on small business. The costs are primarily due not to the regulations but to the legislative enactments that require pharmaceutical services rendered after January 1, 2004 to be paid at 100% of the current Medi-Cal rates. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Pharmacies and other businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

### Specific Technologies or Equipment:

To access Medi-Cal rates from the Division's Internet website, it will be necessary for members of the regulated community to have adequate computer resources. The Division will also provide Medi-Cal rates upon written request.

### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

## **Section 9789.50      Pathology and Laboratory**

### Specific Purpose of Adopted Section 9789.50:

Amended Labor Code § 5307.1(a) provides that the maximum reasonable fees for medical services commencing January 1, 2004, other than physician services, are 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system or 100 percent of the fees prescribed in the relevant Medi-Cal payment system. Proposed Section 9789.50 implements this statutory mandate by providing that the maximum reasonable fees for pathology and laboratory services rendered after January 1, 2004 shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule.

### Necessity:

Pathology and Laboratory services, as identified by proposed Section 9789.11(e), are not physician services and therefore must be paid at 120% of the current Medicare rate for similar services. The Medicare rates are set forth in the CMS Clinical Diagnostic Laboratory Fee Schedule, which can be found on the CMS Internet Website (<http://www.cms.hhs.gov/paymentsystems>) and is incorporated by reference into proposed

Section 9789.50. The fee schedule will also be provided by the Division upon written request.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. CMS Clinical Diagnostic Laboratory Fee Schedule, which can be found on the CMS Internet Website at <http://www.cms.hhs.gov/paymentsystems>.

Business Impact:

This regulation will not have a significant effect on small business. The costs are primarily due not to the regulations but to the legislative enactments that require services commencing January 1, 2004, other than physician services, to be paid at 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.



#### Specific Technologies or Equipment:

To access the Clinical Laboratory Fee Schedule from the CMS Internet website, it will be necessary for members of the regulated community to have adequate computer resources. The Division will also provide the fee schedule upon written request.

#### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

### **Section 9789.60      Durable Medical Equipment, Prosthetics, Orthotics, Supplies.**

#### Specific Purpose of Adopted Section 9789.60:

Amended Labor Code § 5307.1(a) provides that the maximum reasonable fees for medical services commencing January 1, 2004, other than physician services, are 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system or 100 percent of the fees prescribed in the relevant Medi-Cal payment system. Proposed Section 9789.60 implements this statutory mandate by providing that the maximum reasonable fees for durable medical equipment, prosthetics, orthotics, and supplies provided after January 1, 2004 shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule.

#### Necessity:

Durable medical equipment, prosthetics, orthotics, and supplies do not fall within the definition of physician services and therefore must be paid at 120% of the current Medicare rate for similar supplies and services. The Medicare rates are set forth in the CMS DMEPOS Fee Schedule, which can be found on the CMS Internet Website (<http://www.cms.hhs.gov/paymentsystems>) and is incorporated by reference into proposed Section 9789.60. The fee schedule will also be provided by the Division upon written request.

#### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.

2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).
5. CMS DMEPOS Fee Schedule, which can be found on the CMS Internet Website at <http://www.cms.hhs.gov/paymentsystems>.

#### Business Impact:

This regulation will not have a significant effect on small business. The costs are primarily due not to the regulations but to the legislative enactments that require services commencing January 1, 2004, other than physician services, to be paid at 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

To access the DMEPOS Fee Schedule from the CMS Internet website, it will be necessary for members of the regulated community to have adequate computer resources. The Division will also provide the fee schedule upon written request.

#### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

## **Section 9789.70      Ambulance Services**

### Specific Purpose of Adopted Section 9789.70:

Amended Labor Code § 5307.1(a) provides that the maximum reasonable fees for medical services commencing January 1, 2004, other than physician services, are 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system or 100 percent of the fees prescribed in the relevant Medi-Cal payment system. Proposed Section 9789.70 implements this statutory mandate by providing that the maximum reasonable fees for ambulance services rendered after January 1, 2004 shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Ambulance Fee Schedule.

### Necessity:

Ambulance services do not fall within the definition of physician services and therefore must be paid at 120% of the current Medicare rate for similar services. The Medicare rates are set forth in the CMS Ambulance Fee Schedule, which can be found on the CMS Internet Website (<http://www.cms.hhs.gov/paymentsystems>) and is incorporated by reference into proposed Section 9789.70. The fee schedule will also be provided by the Division upon written request.

### Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August

27, 2003 (No. 2003-108.1).

5. CMS Ambulance Fee Schedule, which can be found on the CMS Internet Website at <http://www.cms.hhs.gov/paymentsystems>.

Business Impact:

This regulation will not have a significant effect on small business. The costs are primarily due not to the regulations but to the legislative enactments that require services commencing January 1, 2004, other than physician services, to be paid at 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Businesses can download copies of pricing or ways to determine pricing for specific services from DWC website. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

Specific Technologies or Equipment:

To access the Ambulance Fee Schedule from the CMS Internet website, it will be necessary for members of the regulated community to have adequate computer resources. The Division will also provide the fee schedule upon written request.

Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.

**Section 9789.80      Skilled Nursing Facility      [Reserved]**

**Section 9789.90      Home Health Care      [Reserved]**

**Section 9789.100      Outpatient Renal Dialysis      [Reserved]**

**Section 9789.110      Update of Rules to Reflect Changes in the Medicare Payment System**

Specific Purpose of Adopted Section 9789.70:

Amended Labor Code § 5307.1(g) provides that the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, following consideration of the annual inflation adjustment for facility fees and the annual update in the operating standardized amount and capital standard rate for inpatient hospital services. Subdivision (g)(2) of the statute requires the Administrative Director to determine the effective date of the changes and issue an order, exempt from the rulemaking provisions of the Administrative Procedure Act and the Labor Code

informing the public of the changes and their effective date. All orders issued under subdivision (g)(2) must be posted on the Division's Internet website.

The Administrative Director does not find that regulations are necessary to implement amended Labor Code § 5307.1(g). However, proposed Section 9789.110 informs the regulated community where to locate mandatory Medicare and Medi-Cal updates to the Official Medical Fee Schedule.

Necessity:

Proposed Section 9789.110 reflects the statutory mandate that the Official Medical Fee Schedule conform to any relevant changes in the Medicare and Medi-Cal payment system, and that the Administrative Director issue an order, to be posted on the Division's Internet website, informing the public of such changes. As the changes will be posted on the Division's Internet Website, the Division determined that the most effective manner to inform the regulated community of this requirement was through regulation.

Technical, Theoretical, and/or Empirical Study, Reports or Documents:

The Division of Workers' Compensation posted a draft of the proposed section on its website to allow for pre-notice public comment and relied upon comments received from the public in response to the draft of the proposed sections. The Division also relied upon:

1. Wynn, B., Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program, report prepared for Commissions on Health and Safety and Workers' Compensation, Santa Monica, CA: RAND – Institute for Civil Justice, June, 2003.
2. The California Commission on Health and Safety and Workers' Compensation, Workers' Compensation Medical Payment Systems: A Proposal for Simplification and Administrative Efficiency, report prepared for the Honorable Richard Alarcon, Chair, California Senate Committee on Labor and Industrial Relations, San Francisco, CA: the California Commission on Health and Safety and Workers' Compensation, August 2003.
3. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a report requested by the Joint Legislative Audit Committee, Sacramento, CA: Bureau of State Audits, August 2003 (No. 2003-108.1).
4. California State Auditor, Bureau of State Audits, California Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequately Monitoring of System Costs and Patient Care, a presentation by the California State Auditor for the Conference Committee on Workers' Compensation, Sacramento, CA: Bureau of State Audits, August 27, 2003 (No. 2003-108.1).

#### Business Impact:

This regulation will not have a significant effect on small business. The costs are primarily due not to the regulations but to the legislative enactments that require medical services commencing January 1, 2004, other than physician services, to be paid according to the rules prescribed in the relevant Medicare payment system. Small self-insureds and third party claims administrators will have small initial costs for revising and updating computer systems, average cost per business being \$1000. Larger businesses such as third party administrators, insurance companies, large self-insured employers will have reprogramming costs and may have to renegotiate contracts with medical bill review entities.

#### Specific Technologies or Equipment:

To access orders reflecting changes in the Official Medical Fee Schedule from the Division's Internet website, it will be necessary for members of the regulated community to have adequate computer resources.

#### Consideration of Alternatives:

No more effective alternative, nor equally effective and less burdensome alternative, has been identified by the Administrative Director at this time. The purpose of the present rulemaking is to solicit and consider alternatives.